TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name**
BURLINGAME ORTHOPAEDICS & SPORTS MED

**Respondent Name**
TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**
M4-16-2513-01

**Carrier's Austin Representative**
Box Number 54

**MFDR Date Received**
APRIL 20, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "We received a denial for timely filing, however, we initially submitted this claim in a timely manner on several dates. We initially corrected the CPT WC002 to 99080 on 05/27/2015 and sent a 'corrected claim'. This was also denied for 'duplicate charges' which is not accurate, the claim is still outstanding. The level of service was denied (99214) but we down coded it and re-filed to a 99213 on 07/27/16."

**Amount in Dispute:** $205.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The requestor initially billed code 99214 for the service provided on 4/27/15. Texas Mutual reviewed the bill and documentation and concluded the documentation did not support the use of 99214. The requestor changed the code to 99213 and submitted the bill to Texas Mutual. Texas Mutual received the bill 12/28/15. (Attachment) By changing the code, this made it a new bill that was untimely."

**Response Submitted by:** Texas Mutual Insurance Co.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 27, 2015 | CPT Code 99213<br>Office Visit | $175.00 | $0.00 |
| | CPT Code 99080<br>Special Report or Forms | $30.00 | $0.00 |
| TOTAL | | $205.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the procedure for healthcare providers submitting medical bills.
3. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
4. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - CAC-29-The time limit for filing has expired.
   - 731-Per Rule 133.20(B) provider shall not submit a medical bill later than the 95th day after the date the service.
   - CAC-18-Exact duplicate claim/service.
   - 224-Duplicate charge.

**Issues**

Did the requestor support position that the disputed bills were submitted timely?

**Findings**

According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code "CAC-29-The time limit for filing has expired."

The requestor states, "The level of service was denied (99214) but we down coded it and re-filed to a 99213 on 07/27/16."

The respondent contends that reimbursement is not due because "Texas Mutual received the bill 12/28/15. (Attachment) By changing the code, this made it a new bill that was untimely."

28 Texas Administrative Code §133.20(c) states, "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills."

28 Texas Administrative Code §133.20(f) states, "Health care providers shall not resubmit medical bills to insurance carriers after the insurance carrier has taken final action on a complete medical bill and provided an explanation of benefits except in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills)."

28 Texas Administrative Code §133.20(g) states, "Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier."

A review of the submitted documentation did not include any bills or supporting documentation that the requestor originally billed the respondent for the disputed services using CPT code 99214 rendered on April 27, 2015; therefore, the requestor's position is not supported. The Division finds that based upon the documentation presented the service in dispute is CPT codes 99213 and 99080.

Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

28 Texas Administrative Code §102.4(h), states, "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

To determine when the bills were sent, the Division reviewed the submitted documentation and finds that the requestor did not submit a fax, personal delivery or electronic transmission or a postmark letter to support that the disputed bills were submitted timely in accordance with Texas Labor Code §408.027(a). As a result, reimbursement is not recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | 06/23/2016 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.